

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11279

Reg. Dist. No.

## CERTIFICATE OF DEATH

76

## 1. PLACE OF DEATH:

County CARROLLCity or town WESTMINSTER, ROUTE 6  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? LIFE

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

J. ALBERT ARNOLD

## 3. (b) Social Security Number

NONE4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced MARRIED6.(b) Name of husband or wife EMMA L. ARNOLD6.(c) If alive, give age 67 years7. Birth date of deceased (mo., day, yr.) AUGUST 30, 18738. AGE: Years 75 Months 3 Days  If less than one day  hrs.  min. 9. Birthplace CARROLL COUNTY, MD.  
(Town, county, and state)10. Usual occupation FARMER

## 11. Industry or business

FATHER 12. Name SAMUEL G. ARNOLD13. Birthplace MARYLANDMOTHER 14. Maiden name CAROLINE SAYLOR15. Birthplace MARYLAND16. Informant MRS. J. ALBERT ARNOLDAddress WESTMINSTER, MD. R6.17. BURIAL Date thereof DEC. 3, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory TEER PARK CEM.Location SMALLWOOD, MD.18. Funeral director J. FRANCIS REESEAddress WESTMINSTER, MD.19. 12/1 48 Glendale  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County CARROLLCity or town WESTMINSTER  
(If outside city or town limits, write RURAL and give nearest town)Street No. ROUTE 6

(If rural, give LOCATION)

2.(a) Is veteran, name war NONE

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30 1948 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 10 19

and that I last saw h.  alive on  19

Immediate cause of death

Acute Cardiac decompensationDURATION 1/2 H.Due to Arteriosclerosis years

years

Due to Other conditions 

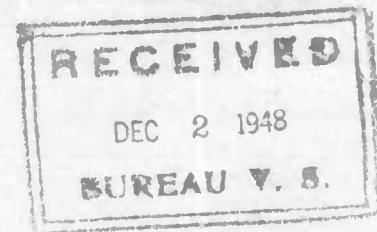
(Include pregnancy within 8 months of death)

Major findings of operations Date of op. Autopsy results 

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of Where did injury occur?  (City or town)  (County)  (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE James & Martha Deely, Medical ExaminersM. D. or other Address Westminster, Md.Date signed 11/30/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Int. correct  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11280

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

79

## 1. PLACE OF DEATH:

County.....  
**Carroll**City or town.....  
**Keymar, Rural**

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....  
**2 yrs**

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

**Mrs. Margaret R. Aurand**

4. Sex      5. Color or race      6. (a) Single, married, widowed, or divorced

**F      W      widow**6. (b) Name of husband or wife.....  
**John L. Aurand**

6. (c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.)  
**March 15, 1855**8. AGE:      Years      Months      Days      If less than one day  
**93      8      9      hrs.      min.**9. Birthplace.....  
(Town, county, and state)  
**Penna**10. Usual occupation.....  
**housework**

## 11. Industry or business

12. Name.....  
**James Boggs**  
13. Birthplace.....  
**Pa**14. Maiden name.....  
**Martha Henryn**15. Birthplace.....  
**Pa**16. Informant.....  
**Harry L. Aurand**Address.....  
**Keymar, Md.**17. Burial.....  
(Burial, cremation, or removal. Which?)  
**Nov. 26, 1948**  
(month) (day) (year)Cemetery or crematory.....  
**Keysville**Location.....  
**Keysville, Md.**18. Funeral director.....  
**C.O. FUSS & SON**Address.....  
**Taneytown, Md.**19. **11/26/48**.....  
(Date rec'd by registrar) **1948**.....  
**Parry M. Powell**.....  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....  
**Penna** County.....City or town.....  
**Philadelphia**

(If outside city or town limits, write RURAL and give nearest town)

Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

**none**

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....  
**Nov. 24 1948** at **6 A.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

**Aug. 6 1948**, to **Nov. 24 1948**.and that I last saw her alive on **Nov. 22 - 1948**.

Immediate cause of death.....

**Arterio Occlusive**

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

**J. H. Legg** M. D. or otherAddress.....  
**Union City**..... Date signed **11-24-48**



Evidence for charge of  
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11281

Film No. G 118 DEC - 6 1948 CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH:

Carroll

County

Henryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

State County

Baltimore 17

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. 602 W. Mount Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Crawford Bailey

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male Col. Separated

6.(b) Name of husband or wife Blanche Bailey

7. Birth date of deceased (mo. day yr.) June 20, 1901 60 years

8. AGE: Years Months Days If less than one day  
47 5 10 hrs. min.

9. Birthplace Accomac County, Virginia  
(Town, county, and state)

10. Usual occupation Pool Room Helper

11. Industry or business

MOTHER FATHER 12. Name John Bull

13. Birthplace Virginia

14. Maiden name Louise Ames

15. Birthplace Virginia

16. Informant Deceased

Address

17. Burial Date thereof Dec-3 1948  
(Burial, cremation, or removal. When?) (month) (day) (year)

Cemetery or crematory Mt Calvary

Location Brooklyn

18. Funeral director T. Brooks Fuggard

Address 17637 Carey St

19. November 30, 1948 (Date rec'd by registrar)

Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30, 1948 at 5:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 3, 1948 to November 30, 1948 and that I last saw him alive on November 30, 1948

Immediate cause of death

Pulmonary Tuberculosis

DURATION

August 1946

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

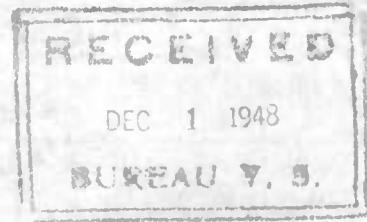
Means of injury

Injured at work?

23. SIGNATURE

Reuben Hoffman, M.D.  
M. D. or other

Address Henryton, Maryland Date signed 11-30-48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11282

## CERTIFICATE OF DEATH

Rug. Dist. No. 74

## 1. PLACE OF DEATH:

County Carroll

City or town Henryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year, 11 months, 23 days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

## 3. (a) FULL NAME

William Thomas Barnett

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male Col. Married

6.(b) Name of husband or wife Etta Barnett

7. Birth date of deceased (mo. day. yr.) February 28, 1882

6.(c) If alive, give age 74 years

8. AGE: Years Months Days If less than one day  
66 8 27 hrs. min.9. Birthplace Baltimore, Maryland  
(Town, county, and state)

10. Usual occupation Night Watchman

## 11. Industry or business

12. Name Solina Barnett

13. Birthplace Maryland

14. Maiden name Josephine Locks

15. Birthplace Maryland

16. Informant Deceased

## Address

11. Burial

(Burial, cremation, or removal. Which?)

Date thereof Nov 29 1946

(month) (day) (year)

Cemetery or crematory Mt. Auburn Cemetery

Location Gaithersburg, Md.

18. Funeral director Mrs. Samuel T. Hensley

Address 578 W. Middle St

19. November 25, 1946  
(Date rec'd by registrar)Albert R. Sneed, Jr.  
Deputy Local Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore 17

(If outside city or town limits, write RURAL and give nearest town)

Street No. 516 W. Mosher Street

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

212-20-4556

## MEDICAL CERTIFICATION

2D. DATE OF DEATH November 25, 1946 at 5:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 2, 1946, to November 25, 1946,

and that I last saw him alive on November 25, 1946.

## Immediate cause of death

Pulmonary Tuberculosis

## DURATION

Sept. 1946

Due to

Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

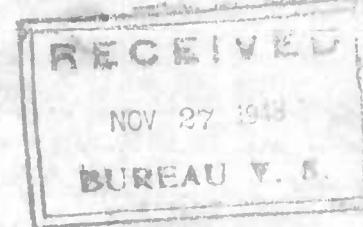
## 23. SIGNATURE

Reuben Hoffman, M.D.

M. D. or other

Address Henryton, Maryland

Date signed 11-25-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age. Is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

B6

11283

Reg. Dist. No. ....

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County... Carroll

City or town... Henryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death... 3 months, 7 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

## 3. (a) FULL NAME

Gloria Anne Bayton

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

female Col. Single

8. (b) Name of husband or wife.....

8. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) February 5, 1931

8. AGE: Years Months Days If less than one day  
17 9 11 hrs. min.9. Birthplace Baltimore, Maryland  
(Town, county, and state)

10. Usual occupation Scholar

11. Industry or business

12. Name Carter Bayton

13. Birthplace Maryland

14. Maiden name Annabelle Owens

15. Birthplace Maryland

16. Informant Annabelle Walls

Address 1318 Fulton Avenue

17. Burial Date thereof Nov. 20, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Calverton

Location Baltimore, Md.

18. Funeral director Geo. S. Nelson

Address 1303 Pilsbury St.

19. November 16, 1948  
(Date rec'd by registrar) Clerk Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland

County...

Baltimore 17,

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1318 Fulton Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 16,

1948, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 9, 1948, to November 16, 1948,  
and that I last saw her alive on November 16, 1948.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

January

1948

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

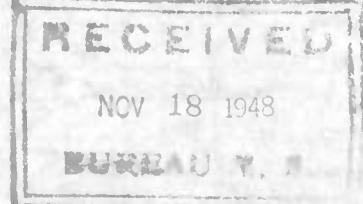
23. SIGNATURE

Reuben Hoffman, M.D.

M. D. or other

Address Henryton, Maryland

Date signed 11-16-48



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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170C

11284

80

Reg. Dist. No.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County... CarrollCity or town... New Windsor - Uniontown road  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?... accidental

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

LeonardBowers

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M WMarried6. (b) Name of husband or wife Mary Rodney Bowers

6. (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 13 - 19198. AGE: Years 29 Months 10 Days 16 It less than one day hrs. .... min.9. Birthplace Carroll County  
(Town, county, and state)10. Usual occupation Farmer

## 11. Industry or business

12. Name Rev Bernie Bowers13. Birthplace Maryland14. Maiden name Virginia Hawk15. Birthplace Maryland16. Informant Mrs Mary R BowersAddress New Windsor, Md Rd

17. Burial

(Burial, cremation, or removal. Which?) Date thereof Dec 1 - 1948

(month) (day) (year)

Cemetery or crematory Piney Creek Brothers CemeteryLocation near Jonestown18. Funeral director O D Hartman & SonsAddress Union Bridge & New Windsor, Md19. Nov 29

1948

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty CarrollCity or town New Windsor, Rural  
(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 29 1948 at 8 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. .... 10. .... 19. ....

and that I last saw h. .... alive on

19. ....

Immediate cause of death

Drowning

DURATION

Due to Froactor upset into Stream

Due to .....

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

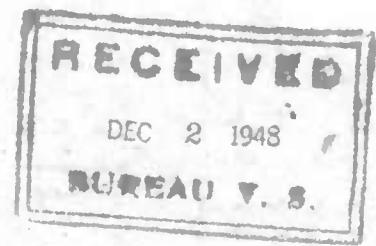
Accident, suicide, or homicide Accident Date of 11-29-48Where did injury occur? Forest Neutralino Tennessee (City or town) (County) (State)Injured at home, farm, industry, public place (where?) House 84Means of injury Froactor upset Injured at work? yes

23. SIGNATURE

James O'Farrell Deputy Medical Examiner

M. D. of other

Address WashingtonDate signed 11-29-48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11285  
13b

## CERTIFICATE OF DEATH

Reg. Dist. No.

74

## 1. PLACE OF DEATH:

County..... Carroll

City or town..... Henryton Maryland

(If outside city or town limits, write RURAL and give nearest town)

20 days

How long in above place of death?

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

## 3. (a) FULL NAME

John Henry Brooks

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced

Male Col. Married

6. (b) Name of husband or wife..... Susie Brooks

8. (c) If alive, give age..... 80 years

7. Birth date of deceased (mo. day yr.)..... November 8, 1875

8. AGE: Years..... Months..... Days..... If less than one day

73 0 17 hrs. min.

9. Birthplace..... Calvert County, Maryland

(Town, county, and state)

10. Usual occupation..... Farmer

## 11. Industry or business

12. Name..... John Parker

13. Birthplace..... Calverv Count, Md.

14. Maiden name..... Georgianna Parker

15. Birthplace..... Calverv County, Md.

16. Informant..... Gladys Brooks (daughter)

Address..... 2440 Brentwood Ave. Baltimore 18, Md.

17. Burial..... Date thereof..... 11-28-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Young's Chapel

Location..... Calvert Cr. Md.

18. Funeral director..... Rev. G. Kelson

Address..... 1303 Preston St.

19. November 25, 1948 Albert R. Hoffman  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore 18

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2440-Brentwood Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... November 25, 1948

at 12:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 5, 1948, to November 25, 1948, and that I last saw him alive on November 25, 1948.

Immediate cause of death.....

Pulmonary Tuberculosis

DURATION

May

1948

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings at operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

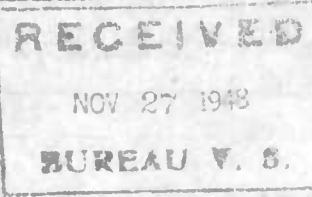
23. SIGNATURE.....

Reuben Hoffman, M.D.

M. D. or other

Address..... Henryton Md.

Date signed..... Nov. 25, 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d 11286

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: Carroll  
 County.....  
 City or town..... Sykesville  
(If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? since October 13, 1925  
 Hospital, institution, or street address where death occurred: Springfield State Hospital  
 How long in hospital or institution? since October 13, 1925

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Maryland County.....  
 City or town..... Baltimore City  
(If outside city or town limits, write RURAL and give nearest town)  
 Street No. ?  
(If rural, give LOCATION)

2.(a) If veteran, name war. ✓

3. (a) FULL NAME CRATE, Herman H.

3. (b) Social Security Number

4. Sex male	5. Color or race white	6.(a) Single, married, widowed, or divorced separated
-------------	------------------------	---

6.(b) Name of husband or wife. ?

7. Birth date of deceased (mo. day. yr.) October 24, 1872

8. AGE: Years 76	Months 1	Days 2	If less than one day hrs. .... min. ....
------------------	----------	--------	--

9. Birthplace..... Baltimore City  
(Town, county, and state)

10. Usual occupation painter

11. Industry or business ---

MOTHER FATHER 12. Name Henry Crate

13. Birthplace Baltimore City

14. Maiden name Sophia Stein

15. Birthplace Baltimore City

16. Informant Records of Springfield State Hospital

Address Sykesville, Md.

17. Removal Date thereof Nov. 28, 1948  
(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location Baltimore Md.

18. Funeral director William Gross, Jr.

Address 1217 St Paul St. Balt. Md.

19. Nov. 28 1948 C. Harry Weiss  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 26 1948 at 5.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 1948 to November 26 1948 and that I last saw him alive on November 26 1948

Immediate cause of death Chronic myocarditis and myocardial degeneration DURATION  
 14 yrs

Due to.

Due to.

Other conditions Arthritis DURATION  
 14 yrs

Manic depressive insanity (Include pregnancy within 8 months of death) DURATION  
 29 yrs

Major findings of operations Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

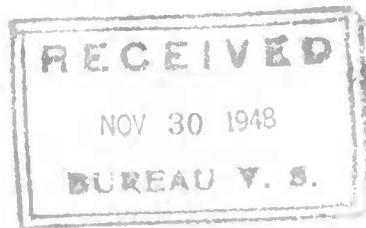
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Martin Gross, M.D. Martin Gross, M.D.

23. SIGNATURE. M. D. or other

Address Sykesville, Md. Date signed 11-26-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. His correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11287

180

Reg. Dist. No. 75

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County

Cecil  
Manchester

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

1 year

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Albert Kline Dell

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m

w

married

6. (b) Name of husband or wife

Edna Biggard

6. (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.)

July 2-1898

8. AGE:

Years

Months

Days

If less than one day

50

4

19

hrs. min.

9. Birthplace

(Town, county, and state)

Md

10. Usual occupation

Laborer

11. Industry or business

General

FATHER

12. Name

Frank Dell

MOTHER

13. Birthplace

Md

14. Maiden name

Penelope Reed

15. Birthplace

Md

16. Informant

Mrs. Albert K. Dell

Address

Manchester Md

17. Burial

Date thereof Nov 28/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Wesley

Location

Cecil Co Md

18. Funeral director

Edwin Tipton

Address

Hampstead Md

19. Nov. 21

1948

Mo. 91. P. S. Dennis

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil

City or town Manchester (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

nd

## 3. (b) Social Security Number

212-14-7312

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 21 1948 at 6:55A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to... 19...

and that I last saw h. alive on 19...

Immediate cause of death

Suffocation and Burn

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Accident Date of 11-21-48

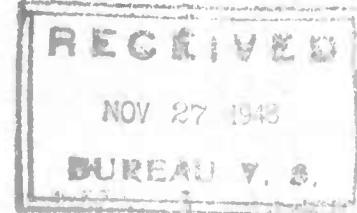
Where did injury occur? Manchester County Md (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Fireburned Injured at work? nd

23. SIGNATURE James T. Monk Deputy Medical Examiner

Address Westminster Md Date signed 11/21/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11288

93d  
SO

## CERTIFICATE OF DEATH

Reg. Dist. No.....

## 1. PLACE OF DEATH:

County..... Carroll

City or town..... New Windsor RD 2

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 9 months

Hospital, institution, or street address where death occurred:

New Windsor RD 2

How long in hospital or institution?.....

## 3. (a) FULL NAME

Robert Parker Durham.

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

M.

W.

W.

6.(b) Name of husband or wife..... Annie E Gibson Durham

7. Birth date of deceased (mo. day, yr.)..... Nov 15 1876

6.(c) If alive, give age..... years

8. AGE: Years Months Days If less than one day

71

11

29

....hrs. ....min.

9. Birthplace..... Wilmington Del.

(Town, county, and state)

10. Usual occupation..... Plumber

11. Industry or business.....

12. Name..... James Hooper Durham

13. Birthplace..... Hyde Md.

14. Maiden name..... Mary Kirk

15. Birthplace..... Middletown Md

16. Informant..... Earl Gibson Durham

Address..... Cedarhurst Md

17. Burial..... Date thereof..... 11-17-48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory..... Reisterstown Meth Cemetery

Location..... Reisterstown Md

18. Funeral director..... Wm Berryman &amp; Sons

Address..... Reisterstown Md

19. Date rec'd by registrar..... Nov 15 1948

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Carroll

City or town..... New Windsor RD 2

(If outside city or town limits, write RURAL and give nearest town)

Street No..... New Windsor Rd

(If rural, give LOCATION)

No

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

216-10-0650

## MEDICAL CERTIFICATION

2D. DATE OF DEATH..... Nov. 14 1948 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1 1948 to Nov. 14 1948

and that I last saw him alive on Oct. 23 1948

Immediate cause of death.....

Cardiac Failure

Due to..... Arteriosclerotic Cardio-  
vascular disease

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

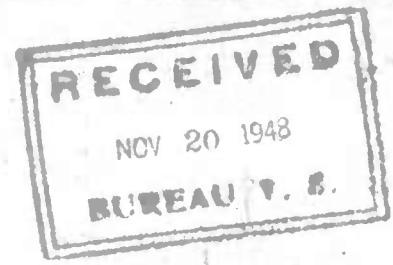
Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE..... Merritt E. Robertson  
M. D. or other.....

Address..... New Windsor, Md. Date signed..... 11/14/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age. Physicians: please write the causes of death clearly and legibly. It is especially important.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

B6  
186

11289

74

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County... Carroll

City or town... Henryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 Months 18 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County...

City or town... Baltimore 1,

(If outside city or town limits, write RURAL and give nearest town)

Street No... 740 Redwood Street,

(If rural, give LOCATION)

2.(a) If veteran, name war...

## 3. (b) Social Security Number

## 3. (a) FULL NAME

Mary Dyson

4. Sex Female 5. Color or race Col. 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) July 18, 1916

8. AGE: Years 32 Months 4 Days 5 It less than one day hrs. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual occupation Laundry

11. Industry or business

12. Name Turner Dyson

13. Birthplace Maryland

14. Maiden name Mary Blake

15. Birthplace Maryland

16. Informant Deceased

Address

17. Burial Date thereof Nov. 26, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mount Calvary  
Location Brooklyn, New York18. Funeral director E. Roy C. Wilson  
Address 1000 Brantley Ave.19. November 23, 1948  
(Date rec'd by registrar)A. H. R. Schallier  
Deputy Local Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 23 1948 at 10:20 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5, 1948, to November 23, 1948,

and that I last saw her alive on November 23, 1948.

Immediate cause of death

Pulmonary Tuberculosis

Due to..... DURATION June 1946

Due to.....

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

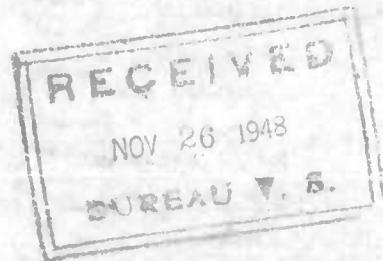
Means of injury

Injured at work?

23. SIGNATURE Neuber Hoffman, M.D.

M. D. or other

Address Henryton, Maryland Date signed 11-23-48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11290

## CERTIFICATE OF DEATH

Reg. Dist. No.

74

## 1. PLACE OF DEATH:

County..... Carroll  
 City or town..... Sykesville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... since 6-11-47  
 Hospital, institution, or street address where death occurred: Springfield State Hospital  
 How long in hospital or Institution?..... since 6-11-47

## 3. (a) FULL NAME

FICKENSCHER, Charles Conrad

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	wid.

6.(b) Name of husband or wife..... Mary Hages, dec.

6.(c) If alive, give age..... years

7. Birth date of deceased (mo. day. yr.) Jan. 5, 1857

8. AGE: Years	Months	Days	It less than one day
91	10	1	hrs. min.

9. Birthplace..... Baltimore City  
 (Town, county, and state)

10. Usual occupation..... Execut. for Union Oil comp.

## 11. Industry or business

12. Name..... Henry Fickenscher

13. Birthplace..... Germany

14. Maiden name..... Sophie Neser

15. Birthplace..... Germany

16. Informant..... Records of Springfield State Hosp.

Address..... Sykesville, Md.

17. Burial..... Date thereof..... 11/8/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Cathedral Cemetery

Location..... Baltimore City, Md.

18. Funeral director..... H.W. Meats, my Son

Address..... 805 N. Calvert St. Balt., Md.

19. Nov. 6 1948 C. Harry Zeller  
 (Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Baltimore County..... City.....  
 City or town..... Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 1028 Cathedral Street  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH..... November 6 1948 at 9.20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 11 1947 to November 6 1948

and that I last saw him alive on November 6 1948

## Immediate cause of death

Arteriosclerosis

DURATION

4 yrs

Due to.....

Due to.....

Other conditions..... Senility

Senile psychosis

(Include pregnancy within 3 months of death)

11 yrs

4 yrs

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

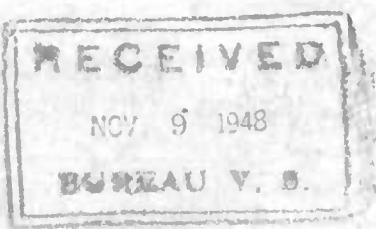
Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

Martin Gross, M.D.

23. SIGNATURE..... Martin Gross, M.D.  
 M. D. or other

Address..... Sykesville, Md. Date signed..... 11-6-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11291

83

## CERTIFICATE OF DEATH

Reg. Dist. No....

1. PLACE OF DEATH: Carroll  
 County.....  
 City or town..... Rural --Woodbine  
 (If outside city or town limits, write RURAL and give nearest town) 6 mo.  
 How long in above place of death?.....  
 Hospital, institution, or street address where death occurred: Hewitt Nursing Home  
 How long in hospital or institution?..... 6 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Maryland County..... Carroll  
 City or town..... Gaither  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME  
 LAURA J. FOWLER

4. Sex Female | 5. Color or race White | 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife..... Vernon Fowler  
 deceased

7. Birth date of deceased (mo., day, yr.) Feb'y 2, 1859

8. AGE: Years 89 | Months 9 | Days 10 | It less than one day hrs. .... min.

9. Birthplace..... Frederick Co., Maryland  
 (Town, county, and state)

10. Usual occupation..... None

11. Industry or business..... Brice Runkles

12. Name..... Brice Runkles  
 13. Birthplace..... Maryland

14. Maiden name..... Not Known

15. Birthplace..... Mrs. Gertrude Poole

16. Informant..... Gaither, Md.  
 Address

17. Burial (Burial, cremation, or removal, which?) Date thereof..... 11-14-48  
 Cemetery..... New Market

Location..... New Market, Frederick Co. Md.

18. Funeral director..... C. M. Waltz  
 Address..... Winfield, Md.

18. (Date rec'd by registrar) Nov 14 48

Registrar

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... November 12 1948 at 12:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1946 19..... to death 19.....

and that I last saw her alive on November 11 1948

Immediate cause of death.....

Due to..... Hypertension -  
 hyperemic cardiovascular disease

Due to..... Arteriosclerosis

.....  
 Due to..... Intestinal obstruction

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE

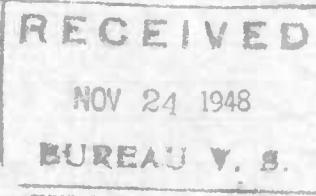
Address.....

M. D. or other

Date signed 11-12-48

STAFF TO TENNESSEE STATE GOVERNOR

PHOTOGRAPHIC EQUIPMENT



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11292

## CERTIFICATE OF DEATH

46 ✓  
Reg. Dist. No. 21

## 1. PLACE OF DEATH:

**Carroll****Taneytown**

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? **50 years**

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

**Laura R. Gilds**

## 4. Sex

**Female**

## 5. Color or race

**white**

## 6. (a) Single, married, widowed, or divorced

**Widow**

## 6. (b) Name of husband or wife

**G. F. Sherman****~~Laura~~ Gilds**

## 7. Birth date of deceased (mo., day, yr.)

**May 13, 1870**

## 6. (c) If alive, give age.....years

## 8. AGE:

**78**

## Years

**5**

## Months

## Days

**20**

## If less than one day

hrs. min.

## 9. Birthplace

**Maryland**

(Town, county, and state)

## 10. Usual occupation

**House work****Own home**

## 11. Industry or business

**Fred Marquet**

## MOTHER FATHER

**Germany**

## 12. Name

**Christiana Stine**

## 13. Birthplace

**Germany**

## 14. Maiden name

## 15. Birthplace

## 16. Informant

**Kenneth R. Gilds**

## 17. Burial

**Taneytown, Maryland**

## Address

## 18. Funeral director

**C.O. Fuss & Son**

## Address

**Taneytown, Maryland.**

## 19. Date rec'd by registrar

**Nov. 4****1948****Mary B. Wilt**

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **Maryland**County **Carroll**City or town **Taneytown**

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

**none**

## MEDICAL CERTIFICATION

2D. DATE OF DEATH **November 2nd** 1948 at **1:15 P.M.**21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **October 27th** 1948 to **November 2nd** 1948and that I last saw her alive on **November 2nd** 1948Immediate cause of death **Examination of Liver**

DURATION

**3 years**

Due to

Due to

Other conditions **Gall Stones 3 years.**

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

**B. M. Benner MD**

M. D. or other

Address **Taneytown, Maryland** Date signed **Nov. 3, 1948**

RECEIVED

NOV 9 1948

BUREAU U. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11293

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County Carroll

City or town Henryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 10 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

## 3. (a) FULL NAME

HELEN GREEN

## 4. Sex

Female

## 5. Color or race

Colored

## 6. (a) Single, married, widowed, or divorced

Married (Sep.)

## 8. (b) Name of husband or wife

T. Birth date of deceased (mo., day, yr.) June 13, 1915

## 8. (c) If alive, give age..... years

## 8. AGE:

Years 33

Months 4

Days 28

If less than one day hrs. min.

## 9. Birthplace Fredrick County, Maryland

(Town, county, and state)

## 10. Usual occupation

None

## 11. Industry or business

Unknown

## 12. Name

Unknown

## 13. Birthplace

Unknown

## 14. Maiden name

Unknown

## 15. Birthplace

Unknown

## 16. Informant

Deceased

## Address

Reservoir

Burial, cremation, or removal. Which?

Date thereof Nov. 13, 48

(month) (day) (year)

Cemetery or crematory City Magazine

Location Baltimore Maryland

## 18. Funeral director Max J. Somers, Jr., Cemetery

Address 578 W. Brodale St.

Nov. 10, 1948

(Date rec'd by registrar)

Albert R. Newell

Deputy Local Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Baltimore 1,

(If outside city or town limits, write RURAL and give nearest town)

Street No. 725 N. Eutaw Street

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 10,

19 48 4:30A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30, 1948 Nov. 10, 1948

and that I last saw her alive on November 10, 1948

## Immediate cause of death

Pulmonary Tuberculosis

DURATION

June 1947

## Due to

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings or operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, list in the following:

Accident, suicide, or homicide..... Date of

## Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

## 23. SIGNATURE

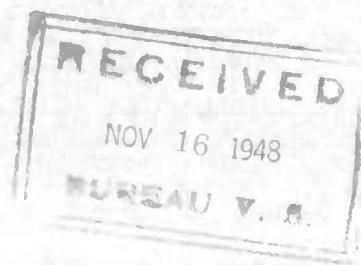
Releen D. Green, M.D.

M. D. or other

Address Henryton, Maryland

Data signed

11-10-48



**M**  
 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and correctly.  
 is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11294  
*13b*

## CERTIFICATE OF DEATH

Reg. Dist. No. *74*

## 1. PLACE OF DEATH:

County ..... Carroll

City or town ..... Rural - Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 yrs, 6 mos, 4 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 23 yrs, 6 mo, 4 days

## 3. (a) FULL NAME

Walter Harding

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

W

Divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

1869

8. AGE: Years

Months

Days

It less than one day

79

hrs.

min.

9. Birthplace

Washington D. C.  
(Town, county, and state)

10. Usual occupation

Stone paver

11. Industry or business

MOTHER

FATHER

12. Name ..... George Harding

13. Birthplace ..... Maryland

14. Maiden name ..... Mary C. Hopper

15. Birthplace ..... Maryland

16. Informant

Hospital records

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 11-28-48  
(month) (day) (year)

Cemetery or crematory

Springfield

Location

Sykesville, Md.

18. Funeral director

P. Harry Weer

Address

Sykesville, Md.

19. Nov. 27, 1948  
(Date rec'd by registrar)C. Harry Weer  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... Md

County .....

Baltimore City

City or town ..... Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. .... ?

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25

19 48 at 6:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10 1946 to Nov. 25 1948

and that I last saw him alive on Nov. 25 1948

Immediate cause of death

Myocardial failure due to mitral and aortic stenosis

Due to

Nephrosclerosis

Due to

Pulmonary tuberculosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

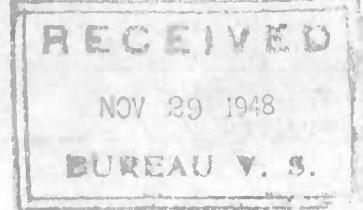
Joseph H. Marshall, M.D.

M. D. or other

Address

Springfield State Hospital

Date signed 11/27/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and clearly.  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11295

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County

City or town

Carroll

Rural - Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

Tyla, 8 mos., 5 days

Springfield State Hospital

How long in hospital or institution?

## 3. (a) FULL NAME

Nyanga Belle Hayter

4. Sex

F

5. Color of face

W

B. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Bayard Hayter

7. Birth date of deceased (mo., day, yr.)

April 12, 1895

8. AGE: Years

50

Months

7

Days

16

If less than one day

hrs. min.

9. Birthplace

Near, Neyden, W. Va.

(Town, county, and state)

10. Usual occupation

Housewife + bookkeeping

11. Industry or business

MOTHER FATHER

12. Name

Robert Bissell

13. Birthplace

W. Va.

14. Maiden name

?

15. Birthplace

?

16. Informant

Hospital records

Address

Burial

17. (Burial, cremation, or removal. Which?)

Date thereof Nov. 30, 1948  
(month) (day) (year)

Cemetery or crematory

Location

Cumberland Md.

18. Funeral director

Ottaway Heer

Address

Sykesville Md.

19. Date rec'd by registrar

Nov. 28 1948

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Md.

County

Allegany

State

City or town

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

116 1/2 W. Third St.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 28,

1948 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

March 23, 1948 to Nov. 28, 1948

and that I last saw her alive on Nov. 27, 1948

Immediate cause of death

Pulmonary tuberculosis

DURATION

1 yr.

Due to

Due to

Other conditions

Schizophrenia, paranoid

4 yrs.

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

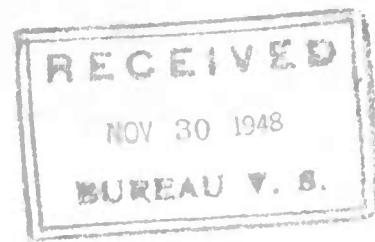
M. D. or other

Address

Joseph X. Marshall, M.D.

Springfield State Hospital

Date signed 11/28/48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11296  
107  
74

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County... Carroll

City or town... Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since 6/28/46

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? since 6/28/46

## 3. (a) FULL NAME

HARTUNG, Albert Theodore

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife... Maida Bowman

6.(c) If alive, give age... 47 years

7. Birth date of deceased (mo. day, yr.)

September 20, 1895

8. AGE: Years	Months	Days	It less than one day
53	1	23	hrs. min.

9. Birthplace... Baltimore City

(Town, county, and state)

10. Usual occupation... Salesman (advertising business)

11. Industry or business ---

MOTHER FATHER John Charles Hartung

13. Birthplace Germany

14. Maiden name Elizabeth ?

15. Birthplace Baltimore, Maryland

16. Informant Records of Springfield St. Hospital

Address Sykesville, Maryland

17. Burial Date thereof Nov. 16-48  
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Westview Cemetery

Location Edmondson Ave

Krause Funeral Home

18. Funeral director

Address 1216 N. Charles St.  
11/16 10.48 A. W. Redick

19. (Date rec'd by registrar)

10.48

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County ---

City or town... Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 3120 Cliftmont Avenue, Balto. 13  
(If rural, give LOCATION)

2.(a) If veteran, name war ---

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 13 1948 at 11,10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 1947 to November 13 1948 and that I last saw him alive on November 13 1948

Immediate cause of death

Bronchopneumonia

DURATION

3 days

Due to

Due to

Other conditions Posttraumatic psychosis 2 yrs

Schizophrenia(?) 13 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. ---

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. --- Date of ---

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury --- Injured at work? ---

23. SIGNATURE Martin Gross, M.D.

Martin Gross, M. D. M. D. or other

Address Sykesville, Maryland Date signed 11-13-48

**M**  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Reg. Dist. No. ....

11297  
83

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County ..... Carroll

City or town ..... Sykesville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 mos

Hospital, institution, or street address where death occurred: North Street

How long in hospital or institution? —

## 3. (a) FULL NAME

ALONZO ALBERT HELTON

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Minnie A. Helton

6. (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years Months Days If less than one day 57 . . . . . hrs. . . . . min.

9. Birthplace Cedar Bluff, Virginia

(Town, county, and state) Laborer

10. Usual occupation.

11. Industry or business Not Known

MOTHER FATHER 12. Name .....

13. Birthplace Not Known

14. Maiden name .....

15. Birthplace Mrs. Minnie A. Helton

16. Informant Address Sykesville, Md.

17. Burial Date thereof 11-26-48

(Burial, cremation, or removal. Which?) Freedom

Cemetery or crematory

Location Freedom, Carroll Co. Md.

18. Funeral director C. M. Waltz

Address Winfield, Md.

19. Date rec'd by registrar Nov 26 1948

Signature Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Carroll

City or town Rural Sykesville  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1000 Street

(If rural, give LOCATION)

2. (a) If veteran, name war.

## 3. (b) Social Security Number

220-10-5771

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. . . . . to 19. . . . .

and that I last saw h . . . . alive on 19. . . . .

Immediate cause of death

Cause Thyrotoxicosis

DURATION

1/2 hr

Due to Chronic Thyrotoxicosis

1948

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James T. March Deputy Medical Examiner

M. D. or other

Address 101 University St. Date signed Nov 24 1948

(Date rec'd by registrar)



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

11298

74

Reg. Dist. No.

## CERTIFICATE OF DEATH

1. PLACE OF DEATH: Carroll

County..... Sykesville

City or town..... (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 years, 1 month, 24 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or Institution? 46 years, 1 month, 24 days

3. (a) FULL NAME

Eliza HINKLE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) (unknown) 181857 (c) If alive, give age ..... years

8. AGE: Years	Months	Days	If less than one day
91			hrs. min.

9. Birthplace..... Maryland (Town, county, and state)

10. Usual occupation..... nurse

11. Industry or business

12. Name	Jacob Hinkle
13. Birthplace	Maryland

14. Maiden name	unknown
15. Birthplace	Germany

16. Informant	Hospital records
Address	Springfield State Hospital

17. Burial	Date thereof 11-20-48 (Burial, cremation, or removal. Which?) (month) (day) (year)
------------	--

Cemetery or crematory	Springfield
Location	Sykesville, Md.

18. Funeral director	C. Harry Weir
Address	Sykesville, Md.

19. Date rec'd by registrar	11-20-48
	C. Harry Weir
	Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town..... Baltimore City

(If outside city or town limits, write RURAL and give nearest town)  
unknown

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 28, 1948 at 10.15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2, 1942, to November 28, 1948, and that I last saw her alive on November 28, 1948.

Immediate cause of death Coronary occlusion DURATION 3 minutes

Due to arteriosclerosis about 6 years

Due to Paranoid condition about 48 years

Other conditions (Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

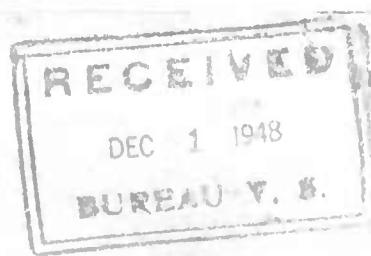
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Irene L. Holman, M.D. M. D. or other

Address Springfield State Hospital Date signed 11-28-48

4981  
16  
3461



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11299  
138

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

Carroll  
County  
Henryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

## 3. (a) FULL NAME

DANIEL BAILEY HOLMES

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

Colored

Married (Sep.)

6.(b) Name of husband or wife

Viola Holmes

7. Birth date of deceased (mo., day, yr.)

June 12, 1904

8. (c) If alive, give age 43 years

8. AGE:

Years

Months

Days

If less than one day

44

4

29

hrs.

min.

9. Birthplace

Baltimore, Maryland

(Town, county, and state)

10. Usual occupation

Seaman

11. Industry or business

MOTHER FATHER

Robert Holmes

13. Birthplace

Virginia

14. Maiden name

Alice Watkins

15. Birthplace

Maryland

16. Informant

Deceased

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Nov. 15, 48  
(month) (day) (year)

Cemetery or crematory Mt. Auburn

Location Westport

18. Funeral director

Mr. Samuel T. Henley

Address

578 Woodlawn St.

19. Nov. 10,

(Date rec'd by registrar)

19. 48

Albert Redman, M.D.  
Deputy Local Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore 1. (If outside city or town limits, write RURAL and give nearest town)

Street No. 511 W. Biddle Street

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

211-09-1359

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 10, 1948, at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 4, 1948, to Nov. 10, 1948,

and that I last saw him alive on November 10, 1948,

Immediate cause of death

Pulmonary Tuberculosis

DURATION

unknown

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

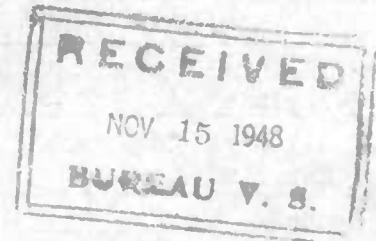
23. SIGNATURE

Reuben G. Holmes, M.D.

M. D. or other

Address Henryton, Maryland

Date signed 11-10-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11360

## CERTIFICATE OF DEATH

48b  
Reg. Dist. No. 83

## 1. PLACE OF DEATH:

County... CarrollCity or town... Woodbine

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?... 1 year

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Grace Frances Dorsay House4. Sex F. 5. Color or race W 6.(a) Single, married, widowed, or divorced Separated6.(b) Name of husband or wife... Wade House7. Birth date of deceased (mo., day, yr.) Sept. 14, 1887 6.(c) If alive, give age? years8. AGE: Years 61 Months 2 Days 16 If less than one day hrs. min.9. Birthplace Md. (Town, county, and state)10. Usual occupation Housewife

## 11. Industry or business

12. Name Frank W. Dorsay13. Birthplace Md.14. Maiden name Annie S. Ritter15. Birthplace Md.16. Informant Mrs. B. Frank Dorsay

Address

Woodbine, Md.17. Burial Date thereof 12-3-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

St. Joseph's

Location

Sykesville, Md.18. Funeral director C. Harry Weir

Address

Sykesville, Md.19. Date rec'd by registrar Dec. 2, 1948 Edna M. Hewitt  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County CarrollCity or town Woodbine (If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 30, 1948 at 5 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1948 to Nov. 30, 1948,and that I last saw her alive on Nov. 30, 1948.

Immediate cause of death

Profound secondary anemiaDue to Carcenoma of uterus

DURATION

2 mo2 yrs

Due to.....

Other conditions General Carcenomatosis6 mo

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

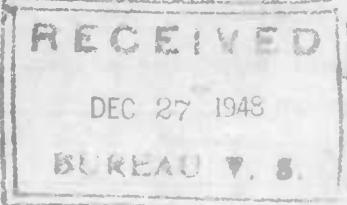
Means of injury

Injured at work?

23. SIGNATURE Stanley Grabill

M. D. or other

Address Mt. Airy, Md.Date signed 12/1/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, in the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11301

83a

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: Carroll  
 County.....  
 City or town..... Sykesville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 year, 18 days  
 Hospital, institution, or street address where death occurred: Springfield State Hospital  
 How long in hospital or institution? 1 year, 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Maryland County..... Allegany  
 City or town..... Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 534 Columbia Avenue  
 (If rural, give LOCATION)

3. (a) FULL NAME Viola Marie Humbertson

3. (b) Social Security Number

4. Sex female	5. Color or race white	6. (a) Single, married, widowed, or divorced widowed
---------------	------------------------	--

6. (b) Name of husband or wife..... Russell Humbertson

7. Birth date of deceased (mo. day. yr.) March 31, 1892

6. (c) If alive, give age..... years

8. AGE: Years 56	Months 8	Days 2	If less than one day hrs. .... min. ....
------------------	----------	--------	---

9. Birthplace..... Eckhart Mines, Maryland  
 (Town, county, and state)

10. Usual occupation..... Maid work

11. Industry or business.....

12. Name..... Isaac Porter
13. Birthplace..... Eckhart Mines, Maryland

14. Maiden name..... Ella Nelson
15. Birthplace..... Eckhart Mines, Maryland

16. Informant..... Hospital records

Address..... Springfield State Hospital

17. Burial..... Date thereof..... Nov 6-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Rose Hill Cemetery  
 Location..... Cumberland 2nd

18. Funeral director..... John J. Hafer

Address..... 230 Baltimore Cumberland

19. Nov 4 1948 C. Harry Zeece  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... November 2, 1948 at 10.05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 28, 1948, to November 2, 1948,

and that I last saw her alive on November 2, 1948.

Immediate cause of death..... Cerebral hemorrhage

xxx Broncho-pneumonia  
 Due to.....

Due to.....

Other conditions..... Involutional psychosis,  
 agitated, depressed type about 2 years  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

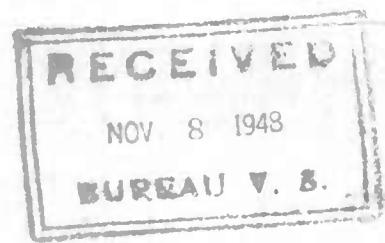
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... June Hebbman, M.D.  
 M. D. or other

Address..... Springfield State Hospital Date signed 11-3-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11302

## CERTIFICATE OF DEATH

Reg. Dist. No. 14

## 1. PLACE OF DEATH:

County Carroll

City or town Henryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year, 1 month, 20 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

## 3. (a) FULL NAME

Estella Lee Johnson

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

female Col. Married

6. (b) Name of husband or wife Ernest Johnson

7. Birth date of deceased (mo., day, yr.) August 15, 1922 8. (c) If alive, give age 34 years

8. AGE: Years Months Days If less than one day  
26 3 5 . . . . . hrs. . . . . min.9. Birthplace Bethel, N. Carolina  
(Town, county, and state)

10. Usual occupation Clothes Company

## 11. Industry or business

12. Name Robert Lee

13. Birthplace N. Carolina

14. Maiden name Martha Williams

15. Birthplace N. Carolina

18. Informant Deceased

## Address

David  
(Burial, cremation, or removal. Which?)Date of death 1948  
(month) (day) (year)

Crematory or crematory

Location

18. Funeral director

Address

19. November 20, 1948  
(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore 23

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9 N. Schroeder Street

(If rural, give LOCATION)

2.(d) If veteran, name war

## 3. (b) Social Security Number

245-01-5827

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 20, 1948 at 4:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 30, 1947, to November 20, 1948,

and that I last saw her alive on November 20, 1948.

Immediate cause of death Pulmonary Tuberculosis

July 1946

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Incident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Reuben Hoffman, M. D.

Henryton, Maryland

Date signed 11-20-48

Deputy Local Registrar



PLEASE WRITE PLAINLY.  
WITH UNFADING INK. Supply every item of information carefully and correctly.  
Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11303  
93d

## CERTIFICATE OF DEATH

Reg. Dist. No.....

## 1. PLACE OF DEATH:

County.....

Carroll

City or town.....

Rural - Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

4 mos. 14 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? .....

4 mos. 14 days

## 3. (a) FULL NAME

John Kaufman

4. Sex

M

Color or race

W

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife.....

Anna Elsa Kaufman

7. Birth date of deceased (mo., day, yr.)

April 9, 1882

6. (c) If alive, give age..... years

8. AGE:

Years  
66Months  
7Days  
21

if less than one day

hrs. .... min.

9. Birthplace.....

Kansas  
(Town, county, and state)

10. Usual occupation.....

Policeman SGT.

11. Industry or business

Retired - BALTIMORE Police Dept

MOTHER FATHER

12. Name..... William Kaufman

13. Birthplace

Pennsylvania

14. Maiden name

Frances Beggs

15. Birthplace

Iowa

16. Informant.....

Hospital records

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 12 - 4 - 48  
(month) (day) (year)

Cemetery or crematory.....

Druid Ridge

Location.....

Baltimore, Md.

18. Funeral director.....

HENRY SANDER &amp; SONS, INC.

Address

NORTH AVE. &amp; BROADWAY

19. Date rec'd by registrar.....

(Date rec'd by registrar)

Dec 2 1948

a.m. Teleph

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County.....

Baltimore

City or town.....

Baltimore 20

Street No.....

Route 15 Box 285

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

217-22-8209

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Nov. 30, 1948 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 16, 1948, to Nov. 30, 1948,

and that I last saw him alive on Nov. 30, 1948.

Immediate cause of death.....

Hypertensive cardiovascular disease

Due to.....

Generalized arteriosclerosis

Due to.....

Psychosis with cerebal arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Joseph H. Marshall, M.D.

M. D. or other

Address

Springfield State Hospital

Date signed 11/30/48

M  
Age

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully and correctly. Physicians: please write the causes of death clearly and legibly is especially important.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

136 Br

11304

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 11 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

## 3. (a) FULL NAME

Catherine Rebecca Kiah

4. Sex: female | 5. Color or race: Col. | 6. (a) Single, married, widowed, or divorced: Separated

6. (b) Name of husband or wife: Aurthur Kiah

7. Birth date of deceased (mo., day, yr.): December 19, 1929 | 8. (c) If alive, give age: 22 years

8. AGE: Years: 18 | Months: 10 | Days: 26 | If less than one day: hrs. min.

9. Birthplace: Baltimore, Maryland  
(Town, county, and state)

10. Usual occupation: None

## 11. Industry or business

Mother Father: 12. Name: Ernest Gales

13. Birthplace: Maryland

14. Maiden name: Martha Houston

15. Birthplace: Maryland

16. Informant: Deceased

## Address

17. Burial: Date thereof: 20. 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Mt. Calvary Cemetery

Location: Balti. Md.

18. Funeral director: Mrs. Katie R. Williams

Address: 322 M. Schrader St.

19. November 15. 1948  
(Date rec'd by registrar)Albert R. Bergman  
Deputy Local Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: ....

City or town: Baltimore 30

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1421 Ward Street

(If rural, give LOCATION)

2.(a) If veteran, name war: ....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH: November 15, 1948, at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 4, 1948, to November 15, 1948,

and that I last saw her alive on November 15, 1948.

## Immediate cause of death:

Pulmonary Tuberculosis

## DURATION

January 1948

Due to: ....

Due to: ....

## Other conditions:

(Include pregnancy within 3 months of death)

## Major findings of operations:

Date of op. ....

## Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: .... Date of: ....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

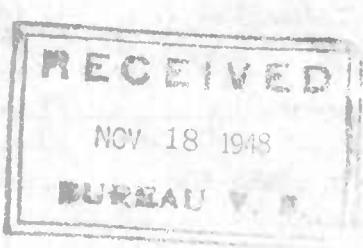
Means of injury: .... Injured at work? ....

23. SIGNATURE: Reuben Hoffman, M.D.

M. D. or other

Address: Henryton, Maryland

Date signed: 11-15-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11305

Bc  
46d

74

Reg. Dist. No.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County.....

Carroll

City or town.....

Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

since March 6, 1948

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution?.....

since March 6, 1948

## 3. (a) FULL NAME

KOZAK, Joseph

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

white

married

6.(b) Name of husband or wife.....

Mary Kozak

7. Birth date of deceased (mo., day, yr.)

?1887?

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

Poland

(Town, county, and state)

10. Usual occupation.....

Shoemaker

11. Industry or business

MOTHER FATHER

12. Name.....

Simon Kozak

13. Birthplace.....

Poland

14. Maiden name.....

Catherine (?)

15. Birthplace.....

Poland

16. Informant.....

Records of Springfield State Hosp.

Address

Sykesville, Md.

11-10-48

17. BURIAL

(Burial, cremation, or removal. Which?)

Cemetery.....

ST. STANISLAUS

Location.....

BALTIMORE, Md.

18. Funeral director.....

George A. Weber

Address

705 South Penn St

19. Date rec'd by registrar

Nov 8 1948

A. W. Helms

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

City or town.....

Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

2114 Eastern Ave

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

November 6

1948

at 12,15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 4 1948 to November 6 1948

end that I last saw him alive on November 6 1948

Immediate cause of death.....

Carcinoma metastases of lungs.

DURATION

6 mo ?

Due to..... Adenocarcinoma of rectum more than 1 yr

Due to.....

Other conditions..... Schizophrenia

30 yrs

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... Metastatic Carcinoma of lungs

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

Martin Gross, M.D.

Martin Gross, M.D.

23. SIGNATURE.....

M. D. or other

Address..... Sykesville, Md.

Date signed 11-6-48

3  
PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully and legibly.  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

466

11306  
81

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County Garrison  
 City or town Union Bridge  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Alice Adele La Forge

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female white married

6. (b) Name of husband or wife Guy S. La Forge

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

May 23 - 1881

8. AGE:

Years

Months

Days

If less than one day

.hrs. ..... min.

9. Birthplace

Bellefonte, Ill.  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

F W Beckford

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

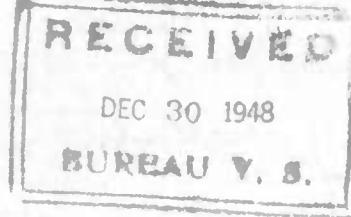
19. Date rec'd by registrar

Date thereof

(month)

(day)

(year)



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11307

## CERTIFICATE OF DEATH

Reg. Distr. No. 75

M  
age

1. PLACE OF DEATH:  
 County Carroll  
 City or town Manchester  
 (If outside city or town limits, write RURAL and give nearest town) 2 miles.  
 How long in above place of death? 2 years.  
 Hospital, institution, or street address where death occurred: Longview Nursing Home.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll  
 City or town Manchester  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 200  
 (If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (b) Social Security Number

Mary E Lauer.

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced M

6.(b) Name of husband Levi Lauer

6.(c) If alive, give age 77 years  
7. Birth date of deceased (mo. day. yr.) Sept 12 - 1875

8. AGE: Years 73 Months 2 Days 9 It less than one day hrs. . min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Mrs

11. Industry or business Jacob Frederick

12. Name Jacob

13. Birthplace Md

14. Maiden name Elizabeth Strine

15. Birthplace Md

16. Informant Levi Lauer

Address Manchester Md

17. Burial Date thereof Nov 24/48  
(Burial, cremation, or removal. When?) (month) (day) (year)

Cemetery or crematory Shemans

Location York Co Penna

18. Funeral director Eddie Grinton

Address Hampstead Md

19. Nov. 21<sup>st</sup> 1948 Mrs. M. P. S. Denner  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 21 1948 at 3 P.M.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from August 1 1948 to Nov 21 1948 and that I last saw her alive on November 20 1948

Immediate cause of death Chronic Myocarditis ?

Due to Hypertensive Cardio-Vascular Disease

Due to Central Hemorrhage 3 m.s.

Other conditions (Include pregnancy within 3 months of death)

Major findings of operations

Date of op. —

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. — Date of —

Where did injury occur? (City or town) (County) (State)

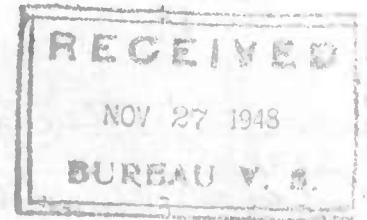
Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Joseph E. Bush M.D.

M. D. or other

Address Hampstead Md Date signed 11-21-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

11308

72

Reg. Dist. No. ....

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

Carroll

County

Near Silver Run

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Westminster, R. D. 1

How long in hospital or institution?

## 3. (a) FULL NAME

George W.C. Leppo (George Wellington Cleason Leppo)

## 3. (b) Social Security Number

None

4. Sex S/Color or race 6.(a) Single, married/widowed, or divorced

Male White Married

6.(b) Name of husband or wife Annie K. (Bowman) Leppo

7. Birth date of deceased (mo., day, yr.) February 25 1869

6.(c) If alive, give age 76 years

8. AGE: Years Months Days It less than one day  
79 8 16 hrs. min.9. Birthplace Carroll County, Md.  
(Town, county, and state)

10. Usual occupation Farming

11. Industry or business Farm

12. Name William A. Leppo

13. Birthplace Carroll County, Md.

14. Maiden name Sarah J. Koontz

15. Birthplace Carroll County, Md.

16. Informant Mrs Annie Leppo

Address Westminster, Md. R. D. 1

17. Burial Date thereof 11/14/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Marys Union Cemetery

Location Silver Run, Md.

18. Funeral director J. W. Little &amp; Son

Address Littlestown, Pa. Per - R. A. Little

19. Nov. 12 - 1948 Calvin P. Bandy, Registrar  
(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Near Silver Run

(If outside city or town limits, write RURAL and give nearest town)

Street No. Westminster, R. D. 1

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

2D. DATE OF DEATH Nov 11

1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to ... 19...

and that I last saw him alive on ... 19...

Immediate cause of death

Cerebral Hemorrhage

DURATION

Due to.....

Due to.....

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

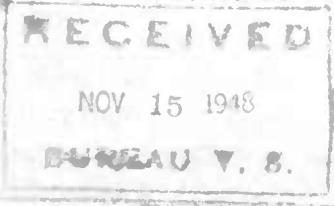
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury ..... Injured at work? .....

23. SIGNATURE

James T. Sharpe, Deputy Medical Examiner  
M. D. or other \_\_\_\_\_  
Address \_\_\_\_\_ Date signed 11/11/48



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11309

76

Reg. Dist. No. 93d

1. PLACE OF DEATH: Carroll  
County.....  
City or town..... Rural-- Westminster

(If outside city or town limits, write RURAL and give nearest town)

1 week

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

ADDIE B. LINDSAY

4. Sex      5. Color or race      6. (a) Single, married, widowed, or divorced

Female      White      Widowed

6. (b) Name of husband or wife.....  
deceased7. Birth date of deceased (mo., day, yr.).....  
March 23, 18808. AGE:      Years      Months      Days      If less than one day  
68      8      7      hrs.      min.

9. Birthplace..... Carroll Co. Maryland

(Town, county, and state)

10. Usual occupation..... None

## 11. Industry or business

FATHER      Charles W. Franklin

12. Name..... Maryland

13. Birthplace..... Annie A. Barnes

MOTHER      Maryland

14. Maiden name..... Mrs. Carvel Horton

15. Birthplace..... Westminster, Md.

16. Informant.....

Address..... Burial

17. (Burial, cremation, or removal, Which?) St. James Date thereof..... 12-4-48  
(month) (day) (year)Cemetery or crematory.....  
Location..... Dennings, Carroll Co. Md.

18. Funeral director..... C. M. Waltz

Address..... Winfield, Md.

19. (Date rec'd by registrar) 12/2/48

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Maryland      County..... BALTIMORE

City or town..... Pikesville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 105 Old Court Road

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov. 30, 1948 at 10:55P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. 10 19

and that I last saw her alive on 19. 10 19

## Immediate cause of death.....

Acute decompression

DURATION

Due to..... Hypertension C-V disease

Due to.....

## Other conditions.....

(Include pregnancy within 3 months of death)

## Major findings of operations.....

Date of op.

## Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

## Means of injury.....

Injured at work?

## 23. SIGNATURE.....

M. D. or other.....

Address..... Waterman, Md. Date signed..... Dec 2 - 48

Registrar

RECEIVED  
DEC 7 1948.  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; in correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

B.C.

11310

## CERTIFICATE OF DEATH

Reg. Dist. No. 24

## 1. PLACE OF DEATH:

County

Carroll

City or town

Rural - Sykesville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

13 mos., 3 days

Hospital, institution, or street address where death occurred

Springfield State Hospital

How long in hospital or institution?

3 mos., 3 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Baltimore City

City or town

Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.

1921 E. Fairmount Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Lena Lopez

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Feb. 24, 1924

8. AGE: Years

24

Months

8

Days

20

If less than one day

hrs.

min.

9. Birthplace

Puerto Rico

(Town, county, and state)

10. Usual occupation

Typist

11. Industry or business

John Lopez

12. Name

Puerto Rico

13. Birthplace

Isabel Beres

14. Maiden name

Puerto Rico

15. Birthplace

Hospital records

16. Informant

Address

Burial, cremation, or removal. Which?

Cremation

Date thereof. Mar. 16, 1948  
(month) (day) (year)

Cemetery or crematory

Location Puerto Rico

18. Funeral director

Address 1217 St Paul St. Balt. Md.

19. Nov. 15 1948

(Date rec'd by registrar)

C. Henry Weir Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 14, 1948 at 12:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 11, 1948 to Nov. 14, 1948

and that I last saw her alive on Nov. 13, 1948

Immediate cause of death

Pulmonary tuberculosis

DURATION

4 mos.  
(known)

Due to

Due to

Other conditions Schizophrenia, paranoid

6 mos.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Joseph H. Marshall, M.D.

M.D. or other

Address Springfield State Hospital Date signed Nov. 14, 1948

RECEIVED

NOV 16 1948

BUREAU F. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1131

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County Carroll

City or town Henryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month 26 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

Colored Branch

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Baltimore County

City or town Cockeysville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Reason Thomas Lynch

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male Colored Married

6.(b) Name of husband or wife Mary Lynch

7. Birth date of deceased (mo., day, yr.) February 28, 1889

8. AGE: Years Months Days If less than one day  
59 9 2 hrs. min.9. Birthplace Montgomery County Maryland  
(Town, county, and state)

10. Usual occupation Laborer

## 11. Industry or business

MOTHER FATHER 12. Name Robert Lynch

13. Birthplace Montgomery County Maryland

14. Maiden name Mary Norman

15. Birthplace Montgomery County Maryland

16. Informant Patient

Address

17. Burial Date thereof Dec. 4-48  
(Burial, cremation, or removal. Which?)

Cemetery or crematory Sugarland

Location Sugarland Md.

18. Funeral director Joseph Janifer

Address 1141 22 st. N.W. Wash. D.C.

19. November 30 1948 Altheath Rebacker  
(Date rec'd by registrar)

Deputy Local

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Baltimore County

City or town Cockeysville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

## 3. (b) Social Security Number

578-22-9036

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 30

1948 at 155 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 4 1948 to November 30 1948

and that I last saw him alive on November 30 1948

## Immediate cause of death

Pulmonary Tuberculosis

DURATION

April 1948

Due to

Due to

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

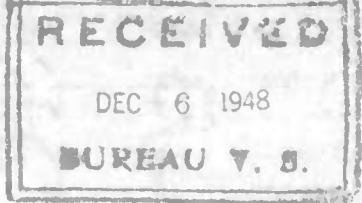
23. SIGNATURE

Reuben Hoffman, M.D.

M. D. or other

Address Henryton, Maryland

Date signed Nov. 30, 1948



Evidence for change of  
birth date shown on:

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11312

81

HLM No. G 118 NOV 23 1948 CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH

County

City or town Union Bridge Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1/2 hr

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Samuel Joseph Mackley

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

W

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 4 1867 1862

8. AGE: Years Months Days If less than one day  
86 8 11 hrs. min.

9. Birthplace

Penn

(Town, county, and state)

10. Usual occupation

Jump Dealer

11. Industry or business

12. Name Jacob L Mackley

13. Birthplace Adam Co Pa

14. Maiden name Lucinda Harbaugh

15. Birthplace Frederick Co Md

16. Informant Mr. Tracy Ester

Address Union Bridge Md

17. Burial Date thereof 11/18/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Beaver Dam

Location Near Union Bridge Md

18. Funeral director Raymond F Wright

Address Union Bridge Md

19. Nov 17 1948 Lila S. Peppa

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Carroll

City or town

Chesapeake

Bridge

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16 1948 at b

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 14 1948 to Nov 16 1948

and that I last saw him alive on Nov 15 1948

Immediate cause of death

Intestinal Flu

DURATION

Due to General arteriosclerosis

Due to

Other conditions

(Indicate pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

D. H. Legg M. D. or other

Address Union Bridge Date signed 11-16-48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11313

## CERTIFICATE OF DEATH

Reg. Dist. No.

92d  
76

## 1. PLACE OF DEATH:

County

Carroll Co.

City or town

Rural near Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

All his life

Hospital, Institution, or street address where death occurred

Carrollton

How long in hospital or institution?

## 3. (a) FULL NAME

Carroll C. Magee

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M.

W.

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

July 10, 1867

8. AGE:

Years

Months

Days

If less than one day

81 7 10 hrs. min.

9. Birthplace

Carrollton, Carroll Co., Md.

(Town, county, and state)

10. Usual occupation

poultry raiser

11. Industry or business

MOTHER

FATHER

Name

Name

13. Birthplace

Name

14. Maiden name

Name

15. Birthplace

Name

16. Informant

Name

Address

Name

17. Burial

Date thereof

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or cemetery

Name

Location

Name

18. Funeral director

Name

Address

Name

19. (Date rec'd by registrar)

1948

L. Woodward

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural near Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. Carrollton station

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 28, 1948, at 10:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 19, 1948, to November 28, 1948,

and that I last saw him dead alive on November 28, 1948.

Immediate cause of death Peritonitis due to clostridium

duration 1 week

Due to Arteriosclerosis generally Severe hypertension degeneration years

Due to Peritonitis &amp; vascular insufficiency

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

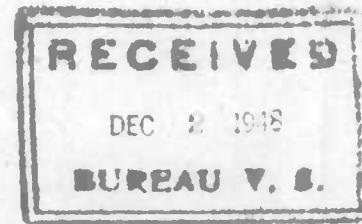
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. G. L. Woodward

M. D. or other

Address Westminster, Md. Date signed 11/30/48



~~PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, as the correctness is especially important. Physicians: please write the causes of death clearly and legibly.~~

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11314  
186a Br

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

## 1. PLACE OF DEATH: Carroll

County Sykesville

City or town (If outside city or town limits, write RURAL and give nearest town)

28 years, 3 months, 24 days

How long in above place of death?

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution?

28 years, 3 months, 24 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Baltimore

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. 2805 Alameda Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Anna Menkins

## 3.(b) Social Security Number

4. Sex female	5. Color or race white	6.(a) Single, married, widowed, or divorced married
---------------	------------------------	---

6.(b) Name of husband or wfe William Menkins

7. Birth date of deceased (mo. day, yr.) June 27, 1887

8. AGE: Years 61 Months 4 Days 17 It less than one day hrs. min.

9. Birthplace Baltimore, Maryland  
(Town, county, and state)

10. Usual occupation House work

11. Industry or business

12. Name Edward Kriegbaum

13. Birthplace Maryland

14. Maiden name Anna Hessenauer

15. Birthplace Maryland

16. Informant Hospital records

Address Springfield State Hospital

17. Burial Date thereof 11-12-48  
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Glen Haven Cem.

Location Glen Burnie Md.

18. Funeral director William Cook, Inc.

Address 1217 8th Paul St.

19. Nov. 15 1948 C. Harry Deere  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 1948 at 11.40 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2, 1942 to November 14, 1948

and that I last saw her alive on November 14, 1948

Immediate cause of death Diabetic coma

Diabetes mellitus

0836 Due to Accidental fracture of femur

Due to Schizophrenia, paranoid type 30 years

Other conditions (Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of Nov. 1948

Where did injury occur? Springfield S. Hosp. Carroll Co. Md.

(City or town) (County) (State)

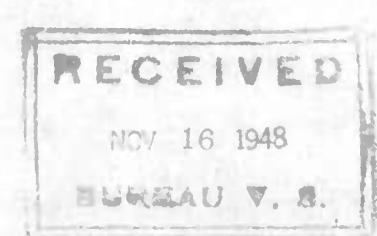
Injured at home, farm, industry, public place (where?) Hosp.

Means of injury Fall Injured at work?

23. SIGNATURE June H. Hensauer, M.D.

M. D. or other

Address Springfield State Hospital Date signed 11-14-48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11315

## CERTIFICATE OF DEATH

B7a  
Reg. Dist. No. 72

1. PLACE OF DEATH:  
 County..... Carroll  
 City or town..... Myers District  
 (If outside city or town limits, write RURAL and give nearest town) 6 years  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 Littlestown, Pa. R.D.I. (Mailing Address)  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Maryland County..... Carroll  
 City or town..... Westminster  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... R. D. 7  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME  
 Jacob Henry Myers  
 4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife..... Virginia (Eckard) Myers  
 7. Birth date of deceased (mo. day, yr.) Sept. 19, 1862 6. (c) If alive, give age. Dead years  
 8. AGE: Years Months Days If less than one day  
 86 2 7 hrs. min.  
 9. Birthplace..... Carroll County, Md.  
 (Town, county, and state)  
 10. Usual occupation..... Retired Farmer  
 11. Industry or business Farming (Retired)  
 12. Name..... Samuel Myers  
 13. Birthplace..... Carroll County, Md.  
 14. Maiden name..... Harriet Dutterer  
 15. Birthplace..... Carroll County, Md.  
 16. Informant..... Mrs. Laurence Haines  
 Address Littlestown, Pa. R.D.I., Carroll Co.  
 17. Burial Date thereof 11/29/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... St. Marys Union Cemetery  
 Location..... Silver Run, Md.  
 18. Funeral director..... J. M. Stuck & Son  
 Address Littlestown, Pa. Per R. A. Stuck  
 19. Nov. 29th 1948 Oakhurst Baptist  
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number  
 None

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 26 1948 at 5:30 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 1948, to Nov. 26, 1948,  
 and that I last saw him alive on Nov. 26, 1948.

Immediate cause of death Hypertrophy of prostate gland  
 Due to.....  
 Duration 10 yrs.

Due to.....  
 Other conditions Chronic cardiac vasculitis  
 died on 15 yrs  
 (Include pregnancy within 3 months of death)

Major findings or operations Hypertrophy of prostate gland  
 Date of op. April 15, 1948

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

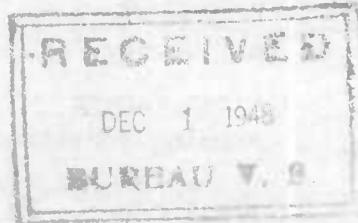
22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel B. Conner, M.D.  
 M. D. or other  
 Address Littlestown, Pa. Date signed 11-26-48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11316

93d

## CERTIFICATE OF DEATH

Reg. Dist. No. 76

## 1. PLACE OF DEATH:

County Carroll

City or town Pleasant Valley

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

William A. Myers

## 4. Sex

M

## 5. Color or race

W

## 6.(a) Single, married, widowed, or divorced

married

## 6.(b) Name of husband or wife

Mary McKinney Myers

## 7. Birth date of deceased (mo., day, yr.)

Dec. 14, 1881

## 6.(c) If alive, give age.....years

## 8. AGE:

66

10

22

Days less than one day

hrs. min.

## 9. Birthplace

Md

(Town, county, and state)

## 10. Usual occupation

Retired Bus Driver

## 11. Industry or business

Frederick H. Myers

## MOTHER FATHER

12. Name

Md

13. Birthplace

## 14. Maiden name

Elenora Geiman

## 15. Birthplace

Md

## 16. Informant

Mrs. Mary McKinney Myers

## Address

Westminster, Md. R.D.

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Nov. 8, 1948  
(month) (day) (year)

St. Matthews

## Cemetery or crematory

Pleasant Valley, Md.

## 18. Funeral director

C.O. FUSS &amp; SON

## Address

Taneytown, Md.

NOV 8 '48

19.

(Date rec'd by registrar)

*E. Lay Fife  
Esq. Esq.  
Registrar*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Pleasant Valley

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

218-10-9540

## MEDICAL CERTIFICATION

Nov. 8 -

1948 at 2:10 P.M.

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1940 to Nov. 5 - 1948

and that I last saw h. E.M. alive on Nov. 4 - 1948

## Immediate cause of death

*Hypertension (cerebral)  
Hypertension (cerebral)*

DURATION

Due to

Due to

Other conditions

*Hypertension*

(Include pregnancy within 8 months of death)

## Major findings or operations

*No op.*

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

*No op.*

Date of

Where did injury occur

*No op.*

(City or town)

(County) (State)

Injured at home, farm, industry, public place (where?)

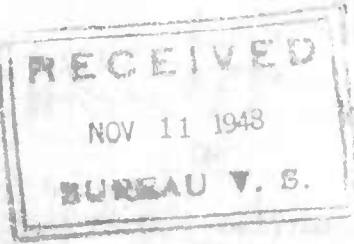
Means of injury

Injured at work?

## 23. SIGNATURE

*W. C. Jernette M.D.  
Westminster, Md. 11-6-48  
Date signed.*

M. D. or other



I

PLEASE WRITE PLAINLY, WITH UNTADING INK. Supply every item of information carefully, in a clear and legible manner. Physicians: please write the causes of death clearly and legibly. It is especially important.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11317

107

Reg. Dist. No. 24

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since January 28, 1947

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? since January 28, 1947

## 3. (a) FULL NAME

NEWCOMER, Lewis Stanop

## 4. Sex

## 5. Color or race

## 6. (a) Single, married, widowed, or divorced

male

white

Widowed

B. (b) Name of husband or wife Maude Tice, deceased

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) August 19, 1878

8. AGE: Year 76 Months 2 Days 16 If less than one day  
..... hrs. ..... min.9. Birthplace Washington County, Maryland  
(Town, county, and state)

10. Usual occupation Carpenter

## 11. Industry or business

12. Name John Robert Newcomer

13. Birthplace Washington County, Maryland

14. Maiden name Josephine Heffner

15. Birthplace Washington County

16. Informant Records of Springfield St. Hospital

Address Sykesville, Maryland

17. Burial Date thereof Nov 7 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rueview

Location Williamsport md

18. Funeral director Leaf Funeral Home Howard J. Stone

Address Williamsport md

19. Death b. 1948  
(Date rec'd by registrar)C. H. Gray, M.D.  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Williamsport

(If outside city or town limits, write RURAL and give nearest town)

Route #2

(If rural, give location)

2.(a) Is veteran, name war \_\_\_\_\_

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 4 1948 11/4 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1, 1947 to 11-3 1948

and that I last saw him alive on November 3 1948

Immediate cause of death

Bronchopneumonia

Due to General and cerebral arteriosclerosis

Due to

Other conditions Hematuria

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

Martin Gross, M. D.

M. D. or other

Address Sykesville, Maryland Date signed 11-4-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of death clearly and legibly.

M

I

B

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11318

74

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:  
County... Carroll  
City or town... Henryton, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 month, 1 day  
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium  
How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State... Maryland County...  
City or town... Baltimore 2  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 700 Sterling Street  
(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

Herbert Lee Northington

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	Col.	Separated
6. (b) Name of husband or wife Mary Northington		
7. Birth date of deceased (mo., day, yr.) October 10, 1907		
6. (c) If alive, give age. 39 years		

8. AGE:	Years	Months	Days	If less than one day
	41	1	5	.hrs. .min.

9. Birthplace... Buchanan, Virginia  
(Town, county, and state)

10. Usual occupation... Metal Cleaner

## 11. Industry or business

MOTHER FATHER	12. Name	Richard Northington
	13. Birthplace	Virginia

MOTHER	14. Maiden name	Emma Harris
	15. Birthplace	Virginia

16. Informant... Deceased

Address

17. Burial Date thereof Nov. 18-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Mt Calvary Cem.

Location... Broadmeadow, Md.

18. Funeral director... Elroy D. Wilson

Address... 1000 Beale St., Ave

19. November 15, 1948  
(Date rec'd by registrar)

Alfred R. Jonathan  
Deputy Local Registrar

## 3. (b) Social Security Number

218-03-1291

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 15, 1948 at 1:25 P.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 14, 1948 to November 15, 1948  
and that I last saw him alive on November 15, 1948.

Immediate cause of death... Pulmonary Tuberculosis  
DURATION March 1948

Due to...  
Due to...  
Other conditions...  
(Include pregnancy within 3 months of death)

Major findings of operations...  
Date of op.

Autopsy results...  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury... Injured at work?

23. SIGNATURE... Nealeen Hoffman, M.D.

M. D. or other

Address... Henryton, Maryland Date signed... 11-15-48

RECEIVED  
NOV 19 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11319

83a

74

Reg. Dist. No.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County Carroll

City or town Sykesville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death since Sept. 25, 1940

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? since Sept. 25, 1940

## 3. (a) FULL NAME

Charles Henry Schroeder

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male white divorced

B. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 1881

8. (c) If alive, give age years

8. AGE: Year

Month

Day

If less than one day

67

/

/

hrs.

min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual occupation laundry worker

11. Industry or business

Christian Schroeder

12. Name Germany

13. Birthplace Mary Smetzer

14. Maiden name

15. Birthplace Germany

16. Informant Springfield State Hospital

Address Sykesville, Maryland

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof 11-20-48

(month) (day) (year)

Cemetery or crematory

Location 1217 St Paul St. Balt. Md.

18. Funeral director William Cook Inc.

Address 1217 St Paul St. Balt. Md.

19. Nov. 20 1948

(Date rec'd by Registrar)

C. Harry Schr.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town ?

(If outside city or town limits, write RURAL and give nearest town)

Street No. ?

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 18, 1948

11 31 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 1 1847 to Nov. 18 1948

and that I last saw him alive on Nov. 18 1948

Immediate cause of death

cerebral hemorrhage

Due to

Due to cerebral arteriosclerosis, chronic alcoholism, bronch. asthma

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

MARTIN GROSS M. D. or other

Address Sykesville, Md. Date signed 11-19-48

RECEIVED

NOV 23 1948

BUREAU F. B. I.

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Br

11320

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County Carroll

City or town Henryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 Hours

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

## 3. (a) FULL NAME

Naomi Estelle Simms

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

female Col. Separated

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) January 19, 1914 6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day  
34 9 16 hrs. min.9. Birthplace Baltimore, Maryland  
(Town, county, and state)

10. Usual occupation None

## 11. Industry or business

12. Name Clifton Mulberry

13. Birthplace (unknown)

14. Maiden name (unknown)

15. Birthplace (unknown)

16. Informant Mrs. Delores Brown

Address 822 Druid Hill Avenue

Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Nov 9 1948

Cemetery or crematory Mt. Auburn

Location

18. Funeral director

Address

November 5, 1948

(Date rec'd by registrar)

Abigail A. Woodward

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Baltimore 1,

(If outside city or town limits, write RURAL and give nearest town)

Street No. 600 W. Mulberry Street

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 5, 1948, at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 4, 1948, to November 5, 1948, and that I last saw her alive on November 5, 1948.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

1943

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

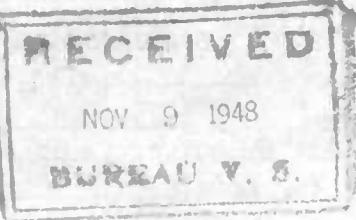
23. SIGNATURE

Reuben Offman, M.D.

M. D. or other

Address Henryton, Maryland

Date signed 11-5-48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11321

## CERTIFICATE OF DEATH

Reg. Dist. No. 76

61

## 1. PLACE OF DEATH:

County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 10 yrs.

Hospital, Institution or street address where death occurred:

Street No. P.D. #7  
How long in hospital or institution?

How long in hospital or institution?

3. (a) FULL NAME

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced W

8. (b) Name of husband or wife William Sipe

7. Birth date of deceased (mo., day, yr.) Feb 28 1875

8. AGE: Years 73 Months 8 Days 25 If less than one day hrs. min.

9. Birthplace York Co Pa

10. Usual occupation Housekeeper

11. Industry or business

MOTHER FATHER 12. Name William F. Old Jr.

13. Birthplace York Co Pa

14. Maiden name Dolores Marcella

15. Birthplace York Co Pa

16. Informant Ethel G. Sipe

Address Mr. Garrison N.Y.

17. Burial Date thereof Jan 26 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or cemetery Shrewsbury Cemetery

Location Shrewsbury Pa

18. Funeral director W. J. G. G. G.

Address Hanover Pa

19. (Date rec'd by registrar) 11/24/48 Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Carroll

City or town Westminister

(If outside city or town limits, write RURAL and give nearest town)

Street No. P.D. #7

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 1948 at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1 1947 to Jan 23 1948

and that I last saw her alive on Jan 22 1948

Immediate cause of death acute cardiac decompensation 12 hrs

chronic myocarditis 142

Due to arteriosclerosis - 1 yrs

Drabition militaris 5 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Lebras R. Gandy M.D.

M. D. or other

Address Westminister Md Date signed Jan 24 1948

RECEIVED

NOV 26 1943

BUREAU U. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11322

**MARYLAND STATE DEPARTMENT OF HEALTH**  
2411 N. Charles St., Baltimore

**CERTIFICATE OF DEATH**

74a  
Reg. Dist. No. 77

**1. PLACE OF DEATH:**  
 County C Carroll  
 City or town Hampstead  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

**3. (a) FULL NAME**  
Howard Samuel Snyder

4. Sex	5. Color of face	6. (a) Single, married, widowed, or divorced
<u>m</u>	<u>w</u>	<u>married</u>

6. (b) Name of husband or wife Minnie Shantz

7. Birth date of deceased (mo., day, yr.) July 17-1873

8. AGE: Years 75 Months 4 Days 1 If less than one day hrs. min.

9. Birthplace Maryland  
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Wm W Snyder

**MOTHER FATHER**

12. Name Eva R Garrett  
 13. Birthplace MD

14. Maiden name Minnie Snyder  
 15. Birthplace MD

16. Informant Mrs Minnie Snyder  
 Address Hampstead MD

17. Burial Date thereof Nov 21/48  
(Burial, cremation, or removal. Which?)

Cemetery or crematory Snyderbury  
 Location Carroll Co Md

18. Funeral director Edie Grapton  
 Address Hampstead MD

19. Nov 20 1948 John S. Hughes Jr.  
(Date rec'd by registrar)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**  
(For newborn infants give residence of mother)

State MD County Carroll  
 City or town Hampstead  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 74a  
(If rural, give LOCATION)

2.(a) If veteran, name war WW

**3. (b) Social Security Number** ✓

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Nov. 18 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_\_, and that I last saw h. alive on \_\_\_\_\_, 19\_\_\_\_\_.  
 Immediate cause of death Coronary occlusion

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Leukemia

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. \_\_\_\_\_

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

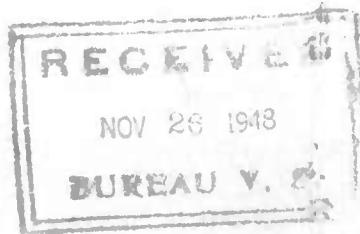
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE James G. Shantz, Deputy Medical Examiner  
M. D. or other

Address Baltimore Md Date signed 11-18-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and correctly. Physicians: please write the causes of death clearly and legibly. It is especially important.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11323

CERTIFICATE OF DEATH *30g*Reg. Dist. No. *74*

## 1. PLACE OF DEATH:

County **Carroll**  
City or town **Sykesville**  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

*since October 17, 1938*

Hospital, institution, or street address where death occurred:

**Springfield State Hospital**

How long in hospital or institution?

*since October 17, 1938*

## 3. (a) FULL NAME

**SPRINGER, Albert**

## 4. Sex

**male**

## 5. Color or race

**white**

## 6.(a) Single, married, widowed, or divorced

**married**

## 6.(b) Name of husband or wife

**?**

## 7. Birth date of deceased (mo., day, yr.)

**Febr. 10, 1874**

## 6.(c) If alive, give age .....

years

## 8. AGE: Years

**74**

## Months

**9**

## Days

**11**

## If less than one day

.....

hrs.

..... min.

## 9. Birthplace

**Maryland**

(Town, county, and state)

## 10. Usual occupation

**Bartender**

## 11. Industry or business

## 12. Name

**Max Springer**

## 13. Birthplace

**Bavaria**

## 14. Maiden name

**Martha Benjamin**

## 15. Birthplace

**Maryland**

## 16. Informant

**Records of Springfield State Hospital**

## Address

**Sykesville, Md.**

## 17. Burial

Date thereof *11-22-48*

(Burial, cremation, or removal. Which?)

(month) (day) (year)

## Cemetery or crematory

**Baltimore Hebrew**

## Location

**Baltimore, Md.**

## 18. Funeral director

**David Goldheim**

## Address

**1902 Bustaw Place**

## 19. Date rec'd by registrar

*Nov. 21 1948*

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **Maryland**County **?**City or town **?**

(If outside city or town limits, write RURAL and give nearest town)

Street No. **?**

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

**November 21****1948****at 10,05A.M.**21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **November 8** **1947** to **November 21** **1948**and that I last saw him alive on **November 21** **1948**Immediate cause of death **Chronic myocarditis and myocardial degeneration plus pyelonephritis**

DURATION

**unknown**

Due to

Due to

Other conditions **Psychosis with pulmonary tuberculosis, systemic syphilis**more than  
**10 yrs**

(Include pregnancy within 3 months of death)

Major findings or operations

**brain atrophy, arteriosclerosis****chronic myocarditis, pyelonephritis**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

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Injured at work

-----

Martin Gross, M.D.

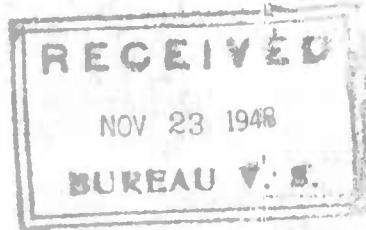
Martin Gross, M.D.

Sykesville, Md.

Date signed *11-21-48*

Address

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of death, write the causes of death clearly and legibly. It is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11324

Reg. Dist. No. ....

74

## CERTIFICATE OF DEATH

Be  
93d

## 1. PLACE OF DEATH:

County... Carroll

City or town... Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8-19-47

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

Now long in hospital or institution? 8-19-47

## 3. (a) FULL NAME

Lewis Stamboni

## 4. Sex

male

## 5. Color or race

white

## 6.(a) Single, married, widowed, or divorced

divorced

## 6.(b) Name of husband or wife

/

## 7. Birth date of deceased (mo., day, yr.)

1-20-76

## 6.(c) If alive, give age years

## 8. AGE:

72

7

5

## Days

If less than one day hrs. min.

## 9. Birthplace

Italy

(Town, county, and state)

## 10. Usual occupation

laborer

## 11. Industry or business

Joseph Stamboni

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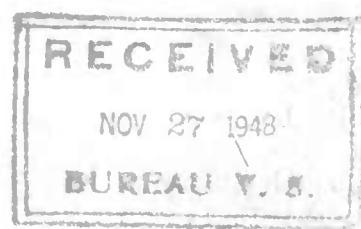
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**M** PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, in correct age  
**S** is especially important. Physicians: please write the causes of death clearly and legibly

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11325

## CERTIFICATE OF DEATH

1312  
Reg. Dist. No. 75

## 1. PLACE OF DEATH:

County.....

City or town.....

*Carroll*  
*Rural Manchester*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

74 years

How long in hospital or institution?

## 3. (a) FULL NAME

*Charles F. Steger*

Sex

Male

5. Color or race

White Wigand

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

*Mary E. Steger (deceased)*

7. Birth date of deceased (mo., day, yr.)

June 18- 1874

6. (c) If alive, give age..... years

8. AGE:

Years      Months      Days      It less than one day

74      5      .8      hrs.      min.

9. Birthplace

Maryland  
(Town, county, and state)

10. Usual occupation

11. Industry or business

Carl E. Steger

12. Name

Germann

13. Birthplace

Imkraeden

14. Maiden name

Germann

15. Birthplace

Walter Steger

16. Informant

Manchester Md.

Address

Burial

(Burial, cremation, or removal. Which?)

Date thereof: 1/28/48  
(month) (day) (year)

Cemetery or crematory

Georgetown

Location

Manchester Md.

18. Funeral director

Jacob Wink's Sons

Address

Manchester Md.

19. Date rec'd by registrar

Nov. 27th 1948 Mrs. W. P. S. Deemer

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland Carroll

County.....

Rural Manchester

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 26 1948

21. CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 23, 1948, to Nov. 26, 1948,

and that I last saw him alive on Nov. 25, 1948.

Immediate cause of death: *General Heart Disease*

DURATION

3 da.

Due to: *Hypertension Cardio-Renal  
Vascular Disease*

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

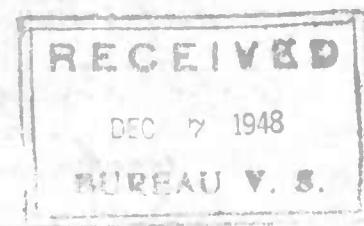
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address: *Jas. E. Bush*Date signed: *1/27/48*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11326

93d  
75

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County

Carroll /  
Baltimore Maryland

City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 weeks.

Hospital, institution, or street address where death occurred:

Lang View Nursing Home

How long in hospital or institution? 2 weeks.

## 3. (a) FULL NAME

Margaret F. Stocks date

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female white Widow -

6.(b) Name of husband or wife William Stocks date

7. Birth date of deceased (mo., day, yr.)

August 15, 1863

8. (c) If alive, give age — years

8. AGE: Years Months Days If less than one day  
85 2 17 hrs. min.

9. Birthplace Frederick County Maryland

(Town, county, and state)

10. Usual occupation None

## 11. Industry or business

12. Name George Metting

13. Birthplace Germany

14. Maiden name Wilhelmina Riebs

15. Birthplace Germany

16. Informant Mrs M. May Hundredmark

Address Upperco, Md.

17. Burial Date thereof Nov 3/48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Paul's

Location Bullock Co. Md

18. Funeral director Edwin G. Gibson

Address Hampstead Md

19. Nov. 2 1948 Mrs. M. P. Fermer

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Upperco Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 1 1948 at 10 40 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 18 1948 to November 1 1948 and that I last saw her alive on October 31 1948

Immediate cause of death Hyperplastic Pneumonia

Due to Chronic Myocarditis

Due to Generalized Arterio-sclerosis

Other conditions General Senility

(Include pregnancy within 8 months of death)

Major findings or operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

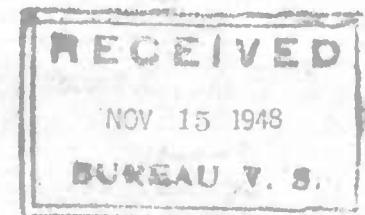
Means of injury — Injured at work? —

23. SIGNATURE Joseph E. Bush Md M. D. or other

Address Hampstead Md Date signed 11-1-48







## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11328  
51b

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White Married

6. (b) Name of husband or wife

Ella T. Steller

7. Birth date of deceased (mo., day, yr.)

Feb. 28-1866

6. (c) If alive, give age . . . years

8. AGE:

Years

Months

Days

If less than one day

82

8

7

hrs.

min.

9. Birthplace

Carroll County, Md.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

12. Name

John Steller

13. Birthplace

Maryland

14. Maiden name

Sarah Young

15. Birthplace

Maryland

16. Informant

Mrs. Ada T. Steller

Address

New Windsor, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery

Cemetery

Location

Clayton's Cemetery

RECEIVED

NOV 23 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Bc

11329

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

74

## 1. PLACE OF DEATH:

Carroll County,

Henryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

## 2. USUAI. RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

County

Baltimore 30

(If outside city or town limits, write RURAL and give nearest town)

Street No. 702 S. Charles Street

(If rural, give LOCATION)

No

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Sam Sumter

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Single

6.(b) Name of husband or wife.....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo. day, yr.) March 24, 1924

8. AGE: Years	Months	Days	It less than one day
24	7	26	hrs. min.

9. Birthplace Columbia, S. Carolina  
(Town, county, and state)

10. Usual occupation Fruitman

11. Industry or business

12. Name Thomas Sumter

13. Birthplace S. Carolina

14. Maiden name Lottie Benson

15. Birthplace S. Carolina

16. Informant Deceased

Address

17. Burial Date thereof. 11-24-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Calvary

Location A.A.C. Med

18. Funeral director James A. Hayes

Address 142 W. Main St

19. November 20, 1948  
(Date rec'd by registrar)Signed R. Sumter  
Deputy Local Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 20, 1948, at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 16, 1948, to November 20, 1948,

and that I last saw him alive on November 20, 1948.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

unknown

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Reuben Hoffman, M.D.

M.D. or other

Address Henryton, Maryland Date signed 11-20-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11330

## CERTIFICATE OF DEATH

Reg. Dist. No. 741

## 1. PLACE OF DEATH:

County Carroll

City or town Henryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months, 29 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

## 3. (a) FULL NAME

Isaih Henry Wallace

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male Col. Married

6.(b) Name of husband or wife Emma Wallace

7. Birth date of deceased (mo., day, yr.) April 4, 1984

6.(c) If alive, give age 36 years

8. AGE: Years Months Days If less than one day  
64 7 9 hrs. min.

9. Birthplace Montgomery County, Maryland

(Town, county, and state)

10. Usual occupation Laborer

## 11. Industry or business

12. Name Urgah Wallace

13. Birthplace Maryland

14. Maiden name Lucy Wing

15. Birthplace Maryland

16. Informant Deceased

Address

17. Burial Date thereof 11/18/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arboretum Park

Location Beltsville, Md

18. Funeral director Mrs. Samuel F. Kennedy  
Address 578 W Bidwell St.19. November 13, 1948 (Date rec'd by registrar)  
Deputy Local

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 921 Linden Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

212-03-8162

## MEDICAL CERTIFICATION

2D. DATE OF DEATH November 13, 1948, at 6:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15, 1948, to November 13, 1948, and that I last saw him alive on November 13, 1948.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

May 1948

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Reuben Hoffman, M.D.

M. D. or other

Address Henryton, Maryland

Date signed 11-13-48

RECEIVED

NOV 16 1948

BUREAU U. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11892

## CERTIFICATE OF DEATH

Reg. Dist. No. 81

## 1. PLACE OF DEATH:

County.....

Carroll

City or town.....

Belvoir

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

38 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Caleb N. Wolfe

4. Sex

5. Color or race

6. (a) Single, married, widowed or divorced

Male

6. (b) Name of husband or wife

White married

Hannah W. Wolfe

7. Birth date of deceased (mo. day. yr.)

6. (c) If alive, give age .....

years

Nov. 20 - 1871

8. AGE:

Years

Months

Days

If less than one day

17 0 hrs. 0 min.

9. Birthplace

(Town, county, and state)

Frederick County, Md.

10. Usual occupation

Farmer

11. Industry or business

MOTHER FATHER

12. Name

Daniel Wolfe

13. Birthplace

Maryland

14. Maiden name

Rebecca Eaves

15. Birthplace

Maryland

16. Informant

Charles M. Wolfe

Address

Belvoir, Maryland

17. Burial

Burial Date thereof Nov. 24-48

(Burial, cremation, or removal. Which?)

Cemetery

Begedad Cemetery

Location

Elton Bridge Rd. S. Rd.

18. Funeral director

D. J. Hartley &amp; Sons

Address

Elton Bridge New Windsor Md.

19. Date rec'd by registrar

Nov. 22 1948

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 21 1948 at 12 noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

am. 1948, to 12 noon 1948

and that I last saw him alive on 21 Nov. 1948

Immediate cause of death

Hemorrhage

DURATION

Due to

Chronic Impending

Other conditions

93d

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

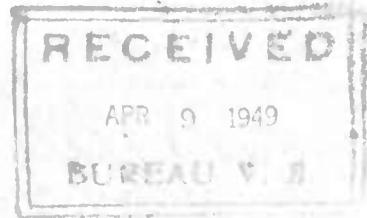
Means of injury Injured at work?

23. SIGNATURE J. A. Weston M.D.

M. D. or other

Address: Elton Bridge Rd. S. Rd. No. 22

Date signed



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11331

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County.....

Carroll

City or town.....

Rural - Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

2 yrs., 5 mos., 9 days

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution?.....

2 yrs., 5 mos., 9 days

## 3. (a) FULL NAME

Ethel Marie Young

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife.....

Kenneth W. Young

7. Birth date of deceased (mo., day, yr.)

March 4, 1906

6.(c) If alive, give age..... years

8. AGE: Years

42

Months

8

Days

24

If less than one day

hrs.

min.

9. Birthplace.....

Frederick County, Md.

(Town, county, and state)

10. Usual occupation.....

Waitress

11. Industry or business

MOTHER FATHER

William H. Mayhugh

12. Name.....

Hancock, Md.

13. Birthplace.....

Claudia H. Panton

14. Maiden name.....

Maryland

15. Birthplace.....

Hospital records

16. Informant.....

Address

17. Burial

(Burial, cremation, or removal. Which)

Date thereof..... Nov. 27, 1948

(month) (day) (year)

Cemetery or crematory.....

Location.....

Frederick, Md.

18. Funeral director.....

M. R. Cetnerowson

Address.....

106 E. Church St.

19. Nov. 24, 1948

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State.....

Md.

County.....

Frederick

City or town.....

Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

329 N. Bentz St.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Nov. 24, 1948 at 3:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 15, 1946, to Nov. 24, 1948, and that I last saw her alive on Nov. 23, 1948.

Immediate cause of death.....

Pulmonary tuberculosis

DURATION

5 mos.

Due to.....

Due to.....

Other conditions..... Schizophrenia, paranoid type

2 1/2 yrs.

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Joseph H. Marshall, M.D.

M. D. or other

Address..... Springfield State Hospital Date signed 11/24/48

